U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 23 June 2003

Case No. 2002-BLA-324

In the Matter of:
BLANCHE CASTLE, WIDOW OF
BOBBY CASTLE,
Claimant,

v.

JOCKEY HOLLOW COAL COMPANY,
Employer,
and
OLD REPUBLIC INSURANCE COMPANY,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:
Stephen Sanders, Esq.
On behalf of Claimant

Lois Kitts, Esq.
On behalf of Employer/Carrier

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977,

30 U.S.C. §§ 901-962, (hereinafter referred to as "the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

Procedural History

Blanche Castle ("Claimant") filed an application for survivor benefits under the Act on April 7, 2000. (DX 1). The Director, Office of Workers' Compensation Programs ("OWCP") denied Claimant's application on June 16, 2000. (DX 15). The OWCP found that Claimant did not qualify for benefits because the evidence did not establish the existence of pneumoconiosis, does not show that the disease was caused at least in part by coal mine work, and does not show that the illness caused the miner's death. On September 12, 2000, counsel for Claimant submitted correspondence, which the OWCP construed as a request for modification of the April 7, 2000 denial of benefits. (DX 16, 26). On October 30, 2000, the OWCP issued a proposed decision and order denying Claimant's request for modification. (DX 28). Claimant requested a formal hearing on November 17, 2000. (DX 31). On January 11, 2001, this case was referred to the Office of Administrative Law Judges by the OWCP for a hearing. (DX 35).[2] After the claim was set for a formal hearing on May 16, 2001, Administrative Law Judge Daniel Roketenetz issued an order cancelling the hearing and remanding the claim to the OWCP to allow the parties to develop additional medical evidence. (DX 37). The OWCP considered additional medical evidence submitted by Claimant, and then denied Claimant's application for benefits on January 16, 2002. (DX 37). Claimant requested a formal hearing. The OWCP transferred Claimant's application to the Office of the Administrative Law Judges on May 16, 2002. (DX 38). A formal hearing on this matter was conducted on October 8, 2002, in Prestonsburg, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES

The issues in this case are:

1. Whether the Miner has pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

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[1]The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[2]In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr" refers to the official transcript of this proceeding.

3. Whether the Miner's death was due to pneumoconiosis; and

4. Whether the evidence establishes a change in conditions and/or that a mistake was made in the determination of any fact in the prior denial under § 725.310.

(DX 28). The issues of whether the Miner's most recent period of cumulative employment of not less than one year was with the named Responsible Operator, whether the regulations are Constitutional, and whether the responsible operator is liable for medical and legal expenses were raised for appellate purposes.

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Bobby Castle ("Miner") was born on September 20, 1928. He married Blanche (Nelson) Castle on August 7, 1954. They lived together until the time of Mr. Castle's death on March 13, 2000. Mrs. Castle has not remarried. I conclude that, for the purposes of eligibility for benefits, Mrs. Castle is the surviving spouse of Bobby Castle. *See* § 725.212.

Length of Coal Mine Employment

Mr. Castle was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations. The parties stipulated that Bobby Castle engaged in coal mine employment for 17 years. I find that the evidence of record supports the parties' stipulation. Therefore, I find that Bobby Castle engaged in coal mine employment for 17 years.

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The OWCP identified Jockey Hollow Coal Company as the putative responsible operator. Therefore, I find that Jockey Hollow Coal Company is properly designated as the responsible operator in this case. *See* §725.493(a)(1).

MEDICAL EVIDENCE

X-RAY REPORTS

The record contains at least sixteen x-ray interpretations from Miner's stay at the St. Joseph's Hospital. The x-rays were not interpreted for the presence or absence of pneumoconiosis, nor were they classified in compliance with the quality standards of § 718.102. An administrative law judge may make an inference as to whether an x-ray is negative or positive. *See Billings v. Harlan #4 Coal Co.*, BRB No. 94-3724 BLA (June 17, 1997)(en

banc)(unpublished). However, the information contained in these x-ray interpretations is not sufficient to allow the undersigned to make an inference regarding the presence or absence of pneumoconiosis.

Exhibit	Date of X-ray	Date of Reading	Physician/Qualifications	Interpretation
EX	12/8/99	6/14/01	Wiot, BCR[2], B-reader[3]	negative
EX	12/8/99	6/22/01	Spitz, BCR, B-reader	negative
EX	1/7/00	6/14/01	Wiot, BCR, B-reader	negative
EX	1/7/00	6/22/01	Spitz, BCR, B-reader	negative

Narrative Medical Evidence

David Rosenberg, M..D., who is board-certified in internal medicine and the subspecialty of internal disease, issued a consultative report on April 10, 2001. (DX 37). He reviewed and summarized Miner's medical records, including the death certificate, hospital records, and consultative reports. He noted that Miner was 71 years old at the time of his death. Dr. Rosenberg documented Miner's long history of coronary artery disease with bypass surgery, hypertension, diabetes, severe peripheral vascular disease, and chronic renal failure. He also noted that Miner was undergoing dialysis over the last several years of his life, in addition to complications of congestive heart failure and sepsis. Dr. Rosenberg considered a smoking history that was long and lasted throughout most of Miner's life. He commented that Miner's PFT tests throughout the record were performed with inadequate effort. Dr. Rosenberg documented notations of cough with sputum production, airway sounds on examination, and various arterial blood gas studies of CO_2 from Miner's treatment notes. He found that Miner's x-rays did not demonstrate evidence of CWP. Dr. Rosenberg opined that the best way to assess the intactness of the interstitium of the lung is by looking at the PO_2 with exercise; he found that Miner's value did not desaturate with exercise, which he opined supports the fact that Miner did not have CWP. Dr. Rosenberg stated that any restriction that was diagnosed based on Miner's PFT values was related to Miner's incomplete effort, not a true restriction. He added that a valid PFT from 1989 showed that Miner's ventilatory status was normal at that time period, which would exclude the presence of any clinically significant obstructive lung disorder at that time. He noted that Miner did have clinical symptoms and findings consistent with COPD in the form of cough, congestion,

[2]A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[3]A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

rhonchi, and wheezes. He found that the ABGs suggest a diagnosis of COPD. Dr. Rosenberg stated that clinically significant airways obstruction is only associated with CWP when complicated CWP is present. Thus, he opined that Miner's COPD was related to his long and extensive smoking history, and not the presence of CWP. He pointed to the death certificate as attributing Miner's death to cardiac and respiratory arrest. Dr. Rosenberg found the etiology of the cardiac and respiratory arrest to be a combination of progressive renal failure requiring dialysis, multiple episodes of congestive heart failure, ventricular arrhythmias, various occurrences of sepsis, and anemia over the last several years of his life.

On April 12, 2001, Gregory Fino, M.D., who is board-certified in internal medicine and the subspecialty of internal disease, issued a supplemental, consultative report. (DX 37). He reviewed and summarized Miner's medical records, as well as his three prior consultative reports dated October 5, 1989, November 17, 1989, and May 11, 1995. Dr. Fino considered a smoking history of up to 50 pack years and a coal mine employment history of 19 years. Dr. Fino stated that there is absolutely no evidence that Miner had a coal mine dust-related pulmonary condition or any evidence of a respiratory impairment. He noted that Miner had severe end-stage coronary artery disease and kidney disease, which was the cause of Miner's death. Dr. Fino opined that CWP was of no discernible consequence in Miner's death. He concluded that CWP neither caused, was related to, nor hastened Miner's death.

N. Roger Jurich, M.D. was deposed on July 11, 2001. (DX 37). He first examined Miner on June 10, 1985. Miner presented to his clinic every month during some years, and every three-to-four months in other years. Dr. Jurich last examined Miner on April 14, 1998. Dr. Jurich stated that Miner suffered from a breathing problem, which he diagnosed as COPD. He noted that Miner complained of shortness of breath, cough productive of sputum, severe episodes of breath requiring multiple types of treatment on numerous occasions. Dr. Jurich found that Miner suffered from a respiratory impairment, noting that Miner had been complaining of progressively worsening smothering since his first visit. Dr. Jurich stated that his diagnosis of COPD was based on history plus physical findings on numerous occasions of rales, rhonchi, and wheezes, which are the sounds that are associated with obstructive airways disease. Dr. Jurich performed a PFT on Miner's first visit, which he interpreted as revealing COPD. When asked if he believed that Miner had a chronic dust disease of the lung, Dr. Jurich responded that Miner had informed him of a 20 year underground coal mine employment history. Thus, Dr. Jurich attributed part of Miner's COPD to coal mine dust exposure. Dr. Jurich commented that he was aware that Miner continued to smoke while he was treating him, and also found a smoking history of one-half to one pack per day for forty years to be consistent with the smoking history that Miner provided to him. He stated that smoking contributes to COPD. Dr. Jurich opined that Miner's smoking history and coal mine employment history caused his COPD. Over the course of his relationship with Miner, Dr. Jurich prescribed IV steroids when Miner was hospitalized, an inhaler, bronchodilators, and antibiotics on numerous occasions for infections in Miner's lungs. Dr. Jurich stated that he did not know what the cause of Miner's death was. However, Dr. Jurich stated that, if Miner was not run over by a truck and if he died from medical causes, he would opine that Miner's COPD was so severe that it would have contributed to Miner's death no matter what the cause was. Dr. Jurich stated that he had also treated Miner for an infection of his prostate gland, peripheral ischemia, renal artery stenosis, kidney failure, bleeding bowels, allergic reactions,

coronary bypass surgery, high blood pressure, kidney infections, diabetes, and blood clots in his legs. Dr. Jurich stated that he never diagnosed CWP himself, only by Miner's history.

Matthew Vuskovich, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary disease, issued a supplemental consultative report on September 22, 2002. (EX 1). He considered a 19 year underground coal mine employment history and a smoking history of many years, which began at the age of 17 and lasted well into the 1990s. Dr. Vuskovich reviewed and summarized Miner's medical records dating back to 1976. He found that the preponderance of the interpretations from B-readers and experienced radiologists indicated that standard chest x-rays did not demonstrate the changes associated with pneumoconiosis. Dr. Vuskovich stated that it was difficult to evaluate Miner's FEV1 and FVC values over the years due to suboptimal effort. He stated that Miner could not be expected to generate valid spirometry after October of 1989 due to Miner's severe heart disease with subsequent pulmonary congestion and decreased exercise capacity. Upon his review of Miner's ABGs, Dr. Vuskovich commented that ABG values after 1976 were consistent with breath holding. He stated that a 1976 ABG showed normal response to exercise. Dr. Vuskovich found that Miner's smoking history of at least 50 years was a major confounding independent non-work related cause of pulmonary disease. He reiterated that Miner's x-rays before 1989 did not reveal evidence of pneumoconiosis, and that after October of 1989, Miner was not able to produce valid spirometry. He concluded that non-work related conditions overwhelmingly confounded any effects of occupational dust disease. Dr. Vuskovich concluded that Miner's death was not caused by nor related to pneumoconiosis, rather severe cardiovascular and renal diseases were the cause. For the sake of accurate public health information, Dr. Vuskovich stated that Miner's death certificate should be corrected. Dr. Vuskovich then stated that the preponderance of the evidence that he reviewed indicated that when Miner quit mining: 1). there was no x-ray evidence of CWP or any other occupational disease; 2). there was no pulmonary or respiratory impairment arising in whole or on part from his coal mining experience; 3). he had the pulmonary capacity to continue working in the coal industry; and 4). there was no evidence of clinically or occupationally significant COPD.

On November 1, 2002, Dr. Jurich provided a narrative comment on Dr. Vuskovich's narrative report. He stated that Miner's work at the face of the coal mine exposed Miner to almost intolerable densities of coal dust, which contributed greatly to the resulting diseases of pneumoconiosis and COPD. In response to Dr. Vuskovich's comment that experienced radiologists never mentioned x-ray findings of pneumoconiosis, Dr. Jurich noted that most of Miner's x-rays were read for routine medical problems; radiologists rarely mention the presence or absence of pneumoconiosis when reading a routine x-ray. He pointed out the interdependence of the human body's systems and the relationship between the kidneys and the lungs in regulating and balancing the electrolytes necessary for all body intracellular functioning. He opined that circulatory and renal, as well as other health problems, can be attributed to Miner's severely compromised respiratory system. Dr. Jurich also found that the development of multiple health problems and the increase in their severity can also be attributed to Miner's compromised pulmonary status secondary to CWP and COPD. Dr. Jurich agrees with Dr. Wright's finding that Miner's pneumoconiosis and bronchitis were perhaps associated with and aggravated by exposure to coal dust. He disagreed with Dr. Vuskovich's conclusion that Miner did not have any significant pulmonary disease. Dr. Jurich argued that, after 1988, there are observations of

dyspnea at rest becoming more pronounced over time, as well as a marked decrease in PO2 and increase in PCO2 with significant decreases in FEV1 and MVV predicted ratios. Overall, Dr. Jurich totally disagrees with Dr. Vuskovich's conclusion, because he believes that Miner had severe COPD which was worsened by coal dust exposure. Dr. Jurich also believes that Miner's severe respiratory problems contributed significantly to his poor health. He noted that Miner did die of natural causes, but concluded that Miner's severe respiratory problems were a significant contributing factor.

Smoking History

Claimant testified that Miner smoked cigarettes until the time of his death, though he had reduced his usage to two or three cigarettes per day. Claimant also testified that the most Claimant had ever smoked was one pack per day. Dr. Rosenberg documented a smoking history that lasted throughout most of Miner's life. Dr. Fino noted a smoking history of up to 50 pack years. Dr. Jurich agreed that a smoking history of one-half to one pack per day for forty years would be consistent with his knowledge of the length of Miner's smoking history. Dr. Vuskovich documented a long smoking history that began when Miner was 17 and lasted into the 1990s. I find that Miner smoked one-half to one pack of cigarettes per day for at least forty years

DISCUSSION AND APPLICABLE LAW

Mrs. Castle filed her survivor's claim on April 7, 2000. Entitlement to benefits must be established under the regulatory criteria at Part 718. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). The Act provides that benefits are awarded to eligible survivors of a miner whose death was due to pneumoconiosis. § 718.205(a). In order to receive benefits, the claimant must prove that:

1). The miner had pneumoconiosis;

2). The miner's pneumoconiosis arose out of coal mine employment; and

3). The miner's death was due to pneumoconiosis.

§§ 718.205(a). Failure to establish any of these elements by a preponderance of the evidence precludes entitlement. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

Modification

Claimant requested modification of the prior denial of her claim. Section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 922, as incorporated into the Black Lung Benefits Act by 30 U.S.C. § 932(a) and as implemented by § 725.310, provides that upon Claimant's own initiative, or upon the request of any party on the ground of a change in

conditions or because of a mistake in a determination of fact, the fact-finder may, at any time prior to one year after the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or a denial of benefits. § 725.310(a).

In deciding whether a mistake in fact has occurred, the United States Supreme Court stated that the Administrative Law Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971). Furthermore, the Sixth Circuit Court of Appeals, under whose appellate jurisdiction this case arises,[4] stated that a modification request need not specify any factual error or change in conditions. *See Consolidation Coal Company v. Director, OWCP [Worrell]*, 27 F.3d 227 (6th Cir. 1994), adopting the Fourth Circuit Court of Appeals standard as set forth in *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993). "A claimant may simply allege that the ultimate fact--disability due to pneumoconiosis--was mistakenly decided, and the deputy commissioner may, if he so chooses, modify the final order on the claim. There is no need for a smoking-gun factual error, changed conditions, or startling new evidence." *Id*.

In determining whether a change in conditions has occurred requiring modification of the prior denial, the Benefits Review Board ("Board") similarly stated that,

> the Administrative Law Judge is obligated to perform an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial), considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

Kingery v. Hunt Branch Coal Co., BRB No. 92-1418 BLA (Nov. 22, 1994); *See also Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993). Furthermore,

> if the newly submitted evidence is sufficient to establish modification . . ., the Administrative Law Judge must consider all of the evidence of record to determine whether Claimant has established entitlement to benefits on the merits of the claim.

Kovac v. BNCR Mining Corp., 14 B.L.R. 1-156 (1990), *modified on recon.*, 16 B.L.R. 1-71 (1992).

In a survivor's claim, the sole ground for modification is that there has been a mistake in a determination of fact; there can be no change in the deceased miner's condition. Therefore, I will analyze the decision of the OWCP denying benefits. If there is a mistake in determination of fact, I will consider all of the evidence of record to determine whether the Claimant has established

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[4] The Benefits Review Board has held that the law of the circuit in which the Claimant's last coal mine employment occurred is controlling. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989). The Claimant's last coal mine employment took place in Kentucky, which falls under the Sixth Circuit's jurisdiction.

entitlement to benefits on the merits of the claim. *See Kovac*, 14 B.L.R. at 1-158. The OWCP found that Claimant did not establish that Miner's death was due to pneumoconiosis arising out of coal mine employment. Claimant alleges two mistaken determinations: 1). that the ultimate issue of total disability due to pneumoconiosis was mistakenly decided by the OWCP, and 2). that the district director lacked authority to issue an amended initial decision and order in 1987. Claimant's second allegation is not properly before the undersigned; it is an issue regarding Bobby Castle's application for living miner benefits. The authority granted to the undersigned in a request for modification is limited to reviewing the previous denial of benefits to see if a mistake occurred in the determination of a fact. The previous denial of benefits only considered Claimant's application for living miner benefits. Therefore, Claimant's request for modification will be granted if the ultimate issue of entitlement to benefits was wrongly decided in the prior denial of benefits.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
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> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
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> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The newly submitted evidence contains four interpretations of two x-rays. All four interpretations are negative for the existence of pneumoconiosis. Therefore, I find that the Claimant has not established the existence of pneumoconiosis by x-ray evidence under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based upon biopsy or autopsy evidence. There is no autopsy evidence in the newly submitted record to consider. Therefore, I find that the Claimant has not established the existence of pneumoconiosis through autopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). The newly submitted record contains narrative opinions from Drs. Fino, Jurich, Rosenberg, and Vuskovich.

Dr. Jurich diagnosed COPD, in part, arising out of coal mine employment. His diagnosis falls under the definition of legal pneumoconiosis. He did not offer an opinion on the presence or absence of clinical pneumoconiosis. Dr. Jurich relied upon a PFT, Miner's history and subjective complaints, and his physical examinations of Miner to render his diagnosis. He considered an accurate account of Miner's smoking and coal mine employment history. Dr. Jurich set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is

well-reasoned and well-documented. In determining the weight to be accorded to a treating physician's opinion, the amended regulations at § 718.104(d) (2002) are not directly applicable because this evidence was developed prior to January 19, 2001, but it is instructive. *See Wolf Creek Collieries v. Director, OWCP [Stephens]*, 298 F.3d 511 (6th Cir. 2002). An administrative law judge may rely upon the well-reasoned and well-documented opinion of a treating physician as substantial evidence in awarding that physician's opinion controlling weight based upon four factors: (1) nature of relationship; (2) duration of relationship; (3) frequency of treatment; and (4) extent of treatment. § 718.104(d) (2002). Dr. Jurich treated Miner for fourteen years, examining Miner on a monthly basis in some years and three-to-four times in other years. He prescribed steroids, inhalers, bronchodilators, and antibiotics to treat Miner's pulmonary condition. During his deposition, Dr. Jurich detailed the precise manner he employed when diagnosing COPD arising in part out of coal mine employment. His candid testimony demonstrated his impartial and accurate approach to diagnosing the existence and etiology of Miner's COPD. Through his status as Miner's treating physician for fourteen years, Dr. Jurich has gained superior and relevant information regarding Miner's physical condition. Even though he holds no special credentials in the area of pulmonary medicine, I accord controlling weight to Dr. Jurich's well-reasoned and well-documented opinion based on the information he gained as Miner's treating physician. *See Gray v. Peabody Coal Co.*, 35 Fed.Appx. 138, 141 (6th Cir. 2002) (unpublished) (where an administrative law judge determines that a treating physician's opinion is credible, the administrative law judge must give more weight to the treating physician's opinion than to those of non-treating physicians).

Dr. Rosenberg opined that there is no evidence of clinical pneumoconiosis based on his review of the x-ray evidence. He also opined that Miner suffered from COPD based on clinical symptoms and findings that were consistent with COPD as well as ABG evidence. However, Dr. Rosenberg attributed Miner's COPD solely to Miner's 50 year history of cigarette smoking because Miner does not have complicated pneumoconiosis, and clinically significant COPD is only associated with the complicated form of CWP. Comment (f) to 20 C.F.R. § 718.201 notes that there is overwhelming scientific and medical evidence that coal mine dust exposure can cause obstructive lung disease. Dr. Rosenberg did not rely upon any medical literature to support his assertion that only complicated pneumoconiosis can cause a clinically significant obstructive lung disease. Yet, this assertion was the sole basis upon which Dr. Rosenberg's based his assertion that Miner's COPD arose out of cigarette smoking. His opinion is not well-reasoned and well-documented. Therefore, I attribute a lesser degree of probative weight to Dr. Rosenberg's opinion.

Dr. Fino opined that there is absolutely no evidence that Miner had a coal mine dust-related pulmonary condition or any evidence of a respiratory impairment. While Dr. Fino provided a lengthy report, including charts of the evidence that he reviewed, there was precious little narrative analysis of the evidence. Dr. Fino's opinions are conclusory. He did not identify the reasoning nor the information upon which he relied to find the absence of a pulmonary or respiratory impairment. Dr. Fino's opinion that pneumoconiosis is absent is not well-reasoned and well-documented. Therefore, I attribute a lesser degree of probative weight to Dr. Fino's opinion.

Dr. Vuskovich found that the x-ray interpretations of the record did not establish the existence of clinical pneumoconiosis. He opined that there was no evidence of clinically or occupationally significant COPD in 1989. Dr. Vuskovich stated that Miner was unable to produce valid spirometry after 1989. He commented that Miner's ABGs after 1989 indicate breath holding, which I infer is a maneuver that detracts from the validity of a study. He also opined that Miner's smoking history of 50 years was a major confounding independent non-work related cause of pulmonary disease. Dr. Vuskovich then concluded that Miner did not have any pulmonary or respiratory impairment arising in whole or on part from his coal mining experience. It is difficult to determine the appropriate weight to accord to Dr. Vuskovich's opinion. It is not evident if Dr. Vuskovich has carefully structured his opinion so as to be ambiguous, or if the ambiguity is the result of a poorly reasoned opinion. For instance, the end of Dr. Vuskovich's report, which purports to be his final diagnosis, only provides his opinion on Miner's condition through 1989. Miner did not die until 2000. Even though Dr. Vuskovich found that all of Miner's PFTs after 1989 were invalid and he discounted Miner's ABGs after 1989, there was still evidence that he could have relied upon to offer an opinion on Miner's physical condition up to his death in 2000. Dr. Vuskovich chose not to address the physical symptoms and findings that Drs. Jurich and Rosenberg both found to be consistent with COPD. He also could have offered an opinion on Miner's baseline pulmonary functioning from the invalid PFTs. Dr. Vuskovich states that Miner's smoking history was a major confounding cause of non-work related pulmonary disease, but he also concluded that there was no evidence of clinically or occupationally significant COPD. Moreover, Dr. Vuskovich's use of the word confounding can be interpreted to mean that there is an additional cause of pulmonary disease to which Miner's smoking history is additive. Dr. Vuskovich's opinion is not well-reasoned and well-documented. I attribute a lesser degree of probative weight to his opinion.

I find that the weight of the newly submitted evidence establishes that Miner suffered from pneumoconiosis. Dr. Jurich's opinion is entitled to controlling weight based upon the superior and relevant information he gained as Miner's treating physician over a fourteen year period. His report and testimony provided compelling evidence that Miner's COPD was caused in significant part by coal dust inhalation. The collective weight accorded to the opinions of Drs. Fino, Rosenberg, and Vuskovich is insufficient to contradict Dr. Jurich's opinion. Drs. Fino, Rosenberg, and Vuskovich were privy to a larger amount of medical evidence than Dr. Jurich, yet they failed to adequately martial the evidence into well-reasoned and well-documented opinions. Dr. Rosenberg and Dr. Jurich both diagnosed COPD, but Dr. Rosenberg failed to provided adequate reasoning to support his opinion on the etiology of Miner's COPD. Dr. Vuskovich opined that Miner did not suffer from COPD, but he did diagnose the existence of a pulmonary disease stemming from Miner's smoking history. Dr. Fino just summarily concluded that Miner didn't have a pulmonary disease at all. Thus, Dr. Jurich's opinion that Miner's COPD was partially, but significantly, related to coal dust inhalation stands as the lone well-reasoned and well-documented opinion regarding the existence of COPD and its etiology. Even if the opinions of Drs. Fino, Rosenberg, and Vuskovich were well-reasoned and well-documented, Dr. Jurich's opinion carries a greater degree of probative weight than their opinions combined. Therefore, I find that Claimant has established the existence of pneumoconiosis under subsection (a)(4) by a preponderance of the newly submitted evidence.

Since Claimant's request for modification is based on an allegation that the ultimate issue of entitlement to benefits was wrongly decided, establishing the existence of pneumoconiosis does not yet prove that the ultimate issue of entitlement was wrongly decided. It would be inappropriate to review all of the evidence as a whole to determine whether Claimant is entitled to benefits at this point. Rather, the analysis of whether the ultimate issue of entitlement was wrongly determined by the OWCP must continue. Therefore, I will determine whether Miner's pneumoconiosis arose out of coal mine employment, and if so, whether his death was due to pneumoconiosis.

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must also prove that pneumoconiosis arose, at least in part, out of Miner's coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* I have determined that Miner was engaged in coal mine employment for seventeen years. Therefore, I find that Miner's pneumoconiosis arose out of his coal mine employment.

Death Due to Pneumoconiosis

Mrs. Castle has established, by a preponderance of the evidence, that Miner suffered from pneumoconiosis arising out of coal mine employment. She must now prove that Miner's death was due to pneumoconiosis in order to be entitled to benefits. Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that an eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that pneumoconiosis was the cause of the Miner's death, or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where death was caused by complications of pneumoconiosis, or

3. Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable.

20 C.F.R. § 718.205(c). Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. § 718.205(c)(5). The presumption set forth in § 718.304 is not applicable, and there is no medical evidence that pneumoconiosis was the direct cause of Miner's death. Therefore, in order for Claimant to be entitled to benefits, she must show that pneumoconiosis hastened Miner's death.

Dr. Rosenberg noted that the death certificate attributed Miner's death to cardiac and respiratory arrest. Dr. Rosenberg opined that a combination of progressive renal failure, congestive heart failure, ventricular arrhythmias, sepsis, and anemia over the last several years of Miner's life caused Miner's cardiac and respiratory arrest. He set forth clinical observations and

findings, and he relied upon adequate data to support his reasoning. I find that Dr. Rosenberg's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Fino stated that Miner's death was caused by severe end-stage coronary artery disease and kidney disease. Thus, he opined that CWP was of no discernible consequence in Miner's death. As previously mentioned, Dr. Fino's opinion was conclusory despite the length evidentiary summarization he performed. He did not provide reasoning to support his conclusions, and he did not identify the evidence that he relied upon to reach his conclusion. I find that Dr. Fino's opinion is not well-reasoned and well-documented. Therefore, I attribute a lesser degree of probative weight to Dr. Fino's opinion.

Dr. Jurich testified that he did not know what Miner's cause of death was, but if Miner's death was due to natural causes, then Dr. Jurich would opine that Miner's COPD would have contributed to his death because his COPD was so severe. Dr. Jurich then responded to Dr. Vuskovich's September 22, 2002 report in a narrative report of his own. He opined that Miner's compromised respiratory system contributed to Miner's circulatory and renal problems because of the interdependent relationship between the kidneys and the lungs in regulating and balancing the electrolytes necessary for intracellular body functioning. Dr. Jurich opined that Miner's development of multiple health problems and their severity can be attributed to Miner's CWP and COPD. Dr. Jurich set forth a sufficient amount of clinical observations and findings for his opinion to be well-documented. However, the record does not support Dr. Jurich's assessment that Miner's COPD was severe, which is the premise that Dr. Jurich relied upon in order to relate COPD to Miner's death. At the time Dr. Jurich rendered this opinion, he was not aware of the manner in which Miner died. He did not identify any supporting rationale for his conclusion. Dr. Jurich provided a more complete analysis of the cause of Miner's death after he read Dr. Vuskovich's report, but it is not clear if Dr. Jurich had access to the medical evidence contained in Dr. Vuskovich's report, or if Dr. Jurich just read Dr. Vuskovich's summary of the evidence. Miner died in 2000 and Dr. Jurich last treated him in 1998. While Dr. Jurich possessed superior and relevant knowledge about Miner's pulmonary condition, he did not hold the same type of knowledge about the circumstances of Miner's death since his treatment relationship had ended. I find that Dr. Jurich's opinion is entitled to a lesser degree of probative weight.

The weight of the newly submitted evidence does not establish that Miner's death was hastened by pneumoconiosis. The direct cause of Miner's death was cardiac and respiratory failure due to coronary artery disease and renal failure. Dr. Jurich's opinion is not sufficient to establish a nexus between Miner's legal pneumoconiosis and his death from cardiac and respiratory failure. Therefore, I find that Claimant has failed to establish that Miner's death was due to pneumoconiosis under § 718.205(c).

Since I have determined that Claimant is not entitled to benefits under the Act, I find that no mistake in the determination of the ultimate fact of eligibility occurred in the OWCP's denial of benefits. Thus, Claimant's request for modification must be denied.

Entitlement

The Claimant, Blanche Castle, has failed to prove that Bobby Castle's death was due to pneumoconiosis by a preponderance of the evidence. Therefore, Mrs. Castle is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Blanche Castle for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**